MDR Tracking Number: M5-05-0988-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on 11-29-04.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor prevailed** on the issues of medical necessity. Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor $650.00** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20 days to the date the order was deemed received as outlined on page one of this order.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was the only issue** to be resolved. The therapeutic activities, level I office visit, manual therapy technique, therapeutic exercises, ultrasound, massage, group therapy and neuromuscular re-education were found to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed services.

This Findings and Decision is hereby issued this 22nd day of February 2005.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay the unpaid medical fees in accordance with the Medicare program reimbursement methodologies effective August 1, 2003 per Commission rule 134.202(c), plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Order is applicable to dates of service 12-08-03 through 02-09-04 in this dispute.

This Order is hereby issued this 22nd day of February 2005.

Margaret Ojeda, Manager
Medical Dispute Resolution
Medical Review Division

MQO/dlh

Enclosure: IRO decision

Envoy Medical Systems, LP
1726 Cricket Hollow
Austin, Texas 78758
Fax 512/491-5145

IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION

February 15, 2005

Re: IRO Case # M5-05-0988-01

Texas Worker's Compensation Commission:

Envoy Medical Systems, LP (Envoy) has been certified as an independent review organization (IRO) and has been authorized to perform independent reviews of medical necessity for the Texas Worker's Compensation Commission (TWCC). Texas HB. 2600, Rule133.308 effective January 1, 2002, allows a claimant or provider who has received an adverse medical necessity determination from a carrier's internal process, to request an independent review by an IRO.

In accordance with the requirement that TWCC assign cases to certified IROs, TWCC assigned this case to Envoy for an independent review. Envoy has performed an independent review of the proposed care to determine if the adverse determination was appropriate. For that purpose, Envoy received relevant medical records, any documents obtained from parties in making the adverse determination, and any other documents and/or written information submitted in support of the appeal.

The case was reviewed by a physician who is Board Certified in Orthopedic Surgery, and who has met the requirements for TWCC Approved Doctor List or has been approved as an exception to the Approved Doctor List. He or she has signed a certification statement attesting that no known conflicts of interest exist between

him or her and any of the treating physicians or providers, or any of the physicians or providers who reviewed the case for a determination prior to referral to Envoy for independent review. In addition, the certification statement further attests that the review was performed without bias for or against the carrier, medical provider, or any other party to this case.

The determination of the Envoy reviewer who reviewed this case, based on the medical records provided, is as follows:

Medical Information Reviewed

1. Table of disputed services
2. Explanation of benefits
3. Peer review 8/26/03
4. Corvel reports 7/15/04, 7/21/04
5. Peer review 7/17/04 Dr. Buczek
6. Synopsis of patient's care 12/31/04 Dr. Nguyen
7. Rehabilitation reports and notes
8. MRI of left shoulder report 8/12/03
9. Notes, Dr. Jarolimek
10. Operative report 10/13/03

History

The patient injured his left shoulder in ___ when he was lifting a 600 pound tire with two other workers. He had severe pain and weakness in his left shoulder and was taken to the emergency room and stabilized. He was then evaluated and treated by a chiropractor. The patient was referred for rehabilitation and medical management, but he continued to have severe pain and weakness. An MRI was obtained on 8/12/03 that revealed a full-thickness rotator cuff tear. The patient was referred to an orthopedic surgeon, and a surgical repair was recommended. The patient underwent repair of a massive left rotator cuff tear with subacromial decompression and insertion of a pain pump for post operative analgesia. Because of the very large tear, the surgeon delayed the patient's physical therapy and placed the patient in a sling for six weeks. The surgeon then recommended a two-phased therapy program by first working on passive ROM, and then active ROM and strengthening.

Requested Service(s)

Therapeutic activities, level 1 office visit, manual therapy technique, therapeutic exercises, ultrasound, massage, group therapy, neuromuscular reeducation 12/8/03 – 2/9/04

Decision

I disagree with the carrier's decision to deny the requested services.

Rationale

The patient had a a rotator cuff tear that required surgical repair. The surgeon documented very well that this was a massive tear, and that he wanted to delay post operative rehabilitation for about six weeks. Rehabilitation was started approximately six weeks post operatively, with a passive, followed by an active ROM and strengthening program. Physical therapy after rotator cuff repair is the standard of care. The services on the dates in dispute represent standard

post operative rehabilitation required after rotator cuff repair. There was no documentation provided that would support that care was excessive or unnecessary

This medical necessity decision by an Independent Review Organization is deemed to be a Commission decision and order.

_____

Daniel Y. Chin, for GP